Comments and Recommendations in the matter of:
Notice of Proposed Rulemaking (NPRM)
WC Docket No. 02-60

From

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June 27, 2002

Summary:

The Northwest TeleHealth network is comprised of over 40 hospitals, clinics and mental health centers in eastern Washington State. The network has been in existence since 1997 and provides access to specialized healthcare, education and administrative conferencing in combination with hospital based computer information networks, imaging and internet access. These integrated services are most commonly delivered over standard T1 communications circuits and more recently through an expanding broadband network of fiber optic connections.

Northwest TeleHealth is constantly called upon to assist network members with Universal Services applications due to the extreme complexity of the process, delays in processing and complex calculations of the standard urban rate and maximum allowable distance. One administrator that I've worked with has had to hire a consultant to help him work through the application process. Needless to say, administrators and CFO's tasked with this process are overwhelmed with all of the steps and determining where they are in the application process. The expenditure of these individuals time detracts even more from the overall financial benefit of the program.

Though cumbersome, the potential financial benefit and contribution toward sustainability of telehealth access from Universal Services discounts is paramount. Expenses from telecommunications circuits are one of the single largest components of access to telehealth and integrated medical information networks. We hope to provide

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comments which will serve to improve the utilization of this program and encourage the simplification of the application process.

Recommendations:

1. The Maximum Allowable Distance Calculation (MAD) should be eliminated.

The Northwest TeleHealth network is receiving more frequent requests to connect to locations on the West side of the state in locations near Seattle and Olympia, the state's capitol. Due to the lack of existing telehealth networks in this area, a need to provide access to extremely specialized services and interconnectivity between entities throughout the state, the network is required to establish links which traverse the state and terminate near large cities such as Olympia or Seattle. Developing broadband networks with increased bandwidth capabilities also traverse the state and create the opportunity for the development of network architectures where bandwidth sharing is becoming more common. Proximity to larger cities of 50,000 or more often negates the possibility of discounted services for entities establishing connections to these networks.

2. The application process should be simplified.

The development of a simplified, single page form such as an "EZ" should be considered. This form should also be constructed in such a manner that "no changes" to communications services can be quickly updated and submitted. Most HCP's do not change services every year or even every 5 years. The entire reapplication process should not be required annually. Billing of services should only be for the discounted amount, eliminating the need to reimburse HCP's for payments. Requiring HCP's to

determine the most cost effective method of calculating their discount should not be left to the HCP. Most are not experts in telecommunications services and must spend extra time in learning unfamiliar processes and terms for complex calculations. If the goal of the program is to indeed "level the playing field" between urban and rural rates, there should not be such a wide discrepancy in rates as typically seen on the Northwest TeleHealth network (25%-57%). A "standard urban rate" should be established by which rural rates can be compared and discounted.

3. Eligible Healthcare Providers should be expanded in scope.

The eligibility list for HCP's is much too restrictive. Similar restrictions were applied to Medicare payments for telehealth consultations which further restricted access to care for rural populations. With a growing number of aging urban and rural patients, it only makes sense to allow "access to services" whether located in a long-term care facility, nursing home or hospice facility. Without affordable communications capabilities, these patients continue to go without availability of services provided through telehealth. EMS agencies are also becoming key to the formation of "alert networks" when dealing with events such as bio-terrorism or meth-lab situations. They also require affordable communications circuits. The list should be expanded to include any rural, not-for-profit healthcare related entity that has a certified Medicare or Medicaid provider number. For-profit healthcare entities should also be included if they are the only provider of services in a rural community.

4. Require Telecommunications Providers to respond within a reasonable timeframe.

Telecommunications providers frequently delay the application process or refuse to cooperate in completing necessary forms. These delays often result in HCP's receiving rebates for services in subsequent years. A process should be implemented to require the provider to complete their responsibilities within a certain timeframe before they are able to bill for services.

5. Remove prorating of services language

For private networks with fixed costs performing telehealth activities, the burden of calculating prorated services should be removed. HCP's not reselling network time but utilizing excess capacity for non-healthcare related activities should not be penalized.

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